SERFF Tracking Number:	*UHLC-126065434*	*State:*	*Arkansas*
Filing Company:	*Unimerica Insurance Company*	*State Tracking Number:*	*41747*
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Erollment Application Enrollment Form*		
Project Name/Number:	*/*		

Filing at a Glance

Company: Unimerica Insurance Company

Product Name: Erollment Application Enrollment Form
SERFF Tr Num: UHLC-126065434
State: ArkansasLH

TOI: H21 Health - Other
Sub-TOI: H21.000 Health - Other
Filing Type: Form

SERFF Status: Closed
Co Tr Num:
Co Status:
Author: Ebony Terry
Date Submitted: 03/08/2009

State Tr Num: 41747
State Status: Approved-Closed
Reviewer(s): Rosalind Minor
Disposition Date: 03/23/2009
Disposition Status: Approved-Closed

Implementation Date Requested: On Approval
Implementation Date:

State Filing Description:

General Information

Project Name:
Project Number:
Requested Filing Mode:
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 03/23/2009

Status of Filing in Domicile: Authorized
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Small
Group Market Type: Employer
Explanation for Other Group Market Type:
State Status Changed: 03/23/2009

Deemer Date:
Corresponding Filing Tracking Number:

Filing Description:

Employer Application Enrollment Form

Company and Contact

Filing Contact Information

Ebony Terry, Compliance Analyst
Ebony_N_Terry@uhc.com

SERFF Tracking Number:	*UHLC-126065434*	*State:*	*Arkansas*
Filing Company:	*Unimerica Insurance Company*	*State Tracking Number:*	*41747*
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Erollment Application Enrollment Form*		
Project Name/Number:	*/*		

4 Taft Court
Rockville, MD 20850

(301) 838-5611 [Phone]
(301) 838-5676[FAX]

Filing Company Information

Unimerica Insurance Company
PO Box 150450
Hartford, CT 0606115-0450
(860) 702-6017 ext. [Phone]

CoCode: 91529
Group Code: 707
Group Name:
FEIN Number: 52-1996029

State of Domicile: Wisconsin
Company Type: Life and Health
State ID Number:

SERFF Tracking Number:	*UHLC-126065434*	*State:*	*Arkansas*
Filing Company:	*Unimerica Insurance Company*	*State Tracking Number:*	*41747*
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Erollment Application Enrollment Form*		
Project Name/Number:	*/*		

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Unimerica Insurance Company	$50.00	03/08/2009	26227132

SERFF Tracking Number:	*UHLC-126065434*	*State:*	*Arkansas*
Filing Company:	*Unimerica Insurance Company*	*State Tracking Number:*	*41747*
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Erollment Application Enrollment Form*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/23/2009	03/23/2009
Approved-Closed	Rosalind Minor	03/11/2009	03/11/2009

Amendments

Item	Schedule	Created By	Created On	Date Submitted
Employer Application Enrollment Form	Form	Ebony Terry	03/16/2009	03/20/2009

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Replacement Application	Note To Filer	Rosalind Minor	03/18/2009	03/18/2009
Small Business Employer Enrollment App	Note To Reviewer	Ebony Terry	03/18/2009	03/18/2009
Underwriting Company	Note To Filer	Rosalind Minor	03/11/2009	03/11/2009

SERFF Tracking Number:	*UHLC-126065434*	*State:*	*Arkansas*
Filing Company:	*Unimerica Insurance Company*	*State Tracking Number:*	*41747*
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Erollment Application Enrollment Form*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 03/23/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*UHLC-126065434*	*State:*	*Arkansas*
Filing Company:	*Unimerica Insurance Company*	*State Tracking Number:*	*41747*
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Erollment Application Enrollment Form*		
Project Name/Number:	*/*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Form *(revised)*	Employer Application Enrollment Form	Approved-Closed	Yes
Form	Employer Application Enrollment Form	Replaced	Yes

SERFF Tracking Number:	*UHLC-126065434*	*State:*	*Arkansas*
Filing Company:	*Unimerica Insurance Company*	*State Tracking Number:*	*41747*
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Erollment Application Enrollment Form*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 03/11/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*UHLC-126065434*	*State:*	*Arkansas*
Filing Company:	*Unimerica Insurance Company*	*State Tracking Number:*	*41747*
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Erollment Application Enrollment Form*		
Project Name/Number:	*/*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Form *(revised)*	Employer Application Enrollment Form	Approved-Closed	Yes
Form	Employer Application Enrollment Form	Replaced	Yes

SERFF Tracking Number:	*UHLC-126065434*	*State:*	*Arkansas*
Filing Company:	*Unimerica Insurance Company*	*State Tracking Number:*	*41747*
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Erollment Application Enrollment Form*		
Project Name/Number:	*/*		

Amendment Letter

Amendment Date:

Submitted Date: 03/20/2009

Comments:

revised form

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
SB.ER.09.AR 2/09	Application/Enrollment Form	Employer Application Enrollment Form	Initial					SB ER 09 ARrevised.pdf

SERFF Tracking Number:	*UHLC-126065434*	*State:*	*Arkansas*
Filing Company:	*Unimerica Insurance Company*	*State Tracking Number:*	*41747*
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Erollment Application Enrollment Form*		
Project Name/Number:	*/*		

Note To Filer

Created By:
Rosalind Minor on 03/18/2009 01:35 PM
Last Edited By:
Rosalind Minor
Submitted On:
03/18/2009 01:35 PM
Subject:
Replacement Application
Comments:
My first Note to Filer indicated that we needed the name of the underwriting company on the application. In the upper right hand corner, the name used is United HealthCare. This is where we need the underwriting company name, Unimerica Insurance Company.

The corrected application should be submitted on the Form schedule. If you have difficulty attaching it to the form schedule, please contact the SERFF help desk.

SERFF Tracking Number:	*UHLC-126065434*	*State:*	*Arkansas*
Filing Company:	*Unimerica Insurance Company*	*State Tracking Number:*	*41747*
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Erollment Application Enrollment Form*		
Project Name/Number:	*/*		

Note To Reviewer

Created By:

Ebony Terry on 03/18/2009 10:52 AM

Last Edited By:

Ebony Terry

Submitted On:

03/18/2009 10:52 AM

Subject:

Small Business Employer Enrollment App

Comments:

I am attempting to attach the revised form. Let me know if you can view it.

(DO NOT STAPLE)

Employer Application for Small Business

[Groups with 2-99 Eligible Employees]

BAR CODE HERE

UnitedHealthcare®
A UnitedHealth Group Company

To avoid processing delays, please make sure you:
1 Answer all questions completely and accurately.
2 Complete and submit the Product and Benefit Selection Form, if applicable.
3 Submit the most recent billing statement listing those currently insured and current status.
4 Submit most recent wage and tax information.
5 Include a deposit check for any required premiums.
6 DO NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTIFICATION OF APPROVAL.

Requested Effective Date

General Information

Group's Legal Name

Group Name to appear on ID card (maximum 30 characters)

Street Address | Tax ID

City | State | Zip Code | Names of Owners/Partners (if applicable)

Contact Person | Telephone | Fax | Email Address

Billing Address (If Different) | # of Years in Business

Organization Type ☐ Partnership ☐ C-Corp ☐ S-Corp ☐ LLC/LLP ☐ Ind. Contractor ☐ Sole Proprietor ☐ Other_____ | Nature of Business | Industry (SIC) Code

Multi-Location Group* ☐ Yes ☐ No | # Locations | Address(es) (or list on additional sheet of paper)

*If you are an employer with a majority of your employees out of the submission state your benefit plans may vary based upon applicable state regulations.

Subject to ERISA regulation ☐ Yes ☐ No

Waiting Period for new hires
☐ 1st of Policy Month following Date of Hire
☐ 1st of Policy Month following ____ [months] [days] of employment
☐ Date of Hire (no waiting period)
☐ ____ [months] [days] of employment following Date of Hire

Waiting Period waived for initial enrollees ☐ Yes ☐ No

Medical Benefit Plan Option ☐ Calendar Year ☐ Policy Year

Have Workers' Comp ☐ Yes ☐ No | Workers' Comp Carrier Name | Names of Owners/Partners not covered by Workers' Comp:

Names of Persons currently on COBRA/Continuation, and/or Short/Long Term Disability: ☐ See Attached List ☐ None

Classes Excluded: ☐ None ☐ Union ☐ Hourly ☐ Non-Management ☐ Non-Owners

Participation		# Employees Applying for:		# Employees Waiving for:		Contribution	Employer %	Employer % for Dep
# Eligible Employees		Medical		Medical		Medical		
# Ineligible Employees		Dental		Dental		Dental		
Total # Employees		Vision		Vision		Vision		
		Basic Life/AD&D		Basic Life/AD&D		Basic Life/AD&D		
		Dep Life		Dep Life		Dep Life		
# Hours per week to be eligible** _____		Supp Life/AD&D		Supp Life/AD&D		Supp Life/AD&D		
		Dep Supp Life/AD&D		Dep Supp Life/AD&D		Dep Supp Life/AD&D		
		STD		STD		STD		
**For Disability products the minimum # of work hours per week to be eligible is 30 hours.		STD Buy Up		STD Buy Up		STD Buy Up		
		LTD		LTD		LTD		
		LTD Buy Up		LTD Buy Up		LTD Buy Up		
		Other		Other		Other		

Coverage Provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by UnitedHealthcare Insurance Company or United HealthCare of Arkansas, Inc.
Dental coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company
Life Insurance coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company
Vision coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company

General Information (continued)

Do you currently offer or intend to offer a Health Reimbursement Account (HRA) plan and/or comprehensive supplemental insurance policy or funding arrangement in addition to this UnitedHealthcare medical plan?
Answers must be accurate whether purchased from UnitedHealthcare or any other insurer or third party administrator.
HRA ☐ Yes ☐ No
If yes, please identify type: ☐ UnitedHealthcare Definity HRA (any HRA design offered through UnitedHealthcare) ☐ Other Administrator HRA
HRA plans administered by other insurers or third party administrators must comply with UnitedHealthcare HRA design standards.

Comprehensive Supplemental Insurance Policy or Funding Arrangement ☐ Yes ☐ No

If you answered "Yes" to either question above, you must choose from the list of UnitedHealthcare Definity HRA-eligible medical plans as shown to you by your broker or agent. Other plans are not eligible for pairing with these arrangements. Purchase of such arrangements at any point during the duration of this policy will require you to notify UnitedHealthcare.

What is your administrative policy regarding termination of eligibility for benefits related to your medical policy (including, but not limited to termination following a leave of absence)? (Please refer to the applicable state and federal rules that may require benefits to be provided for a specific length of time while an employee is on leave.)

☐ Last Day worked (following the last day worked for the minimum hours required to be eligible)
☐ 3 Months (following the last day worked for the minimum hours required to be eligible)
☐ 6 Months (following the last day worked for the minimum hours required to be eligible)
☐ UnitedHealthcare Policy Special Provisions Related to Medical Eligibility*
☐ Other (please provide a copy for our records)

***UnitedHealthcare Special Provisions Related to Medical Eligibility**

If the employer continues to pay required medical premiums and continues participating under the medical policy, the covered person's coverage will remain in force for: (1) No longer than 3 consecutive months if the employee is: temporarily laid-off; in part time status; or on an employer approved leave of absence. (2) No longer than 6 consecutive months if the employee is totally disabled.

If this coverage terminates, the employee may exercise the rights under any applicable Continuation of Medical Coverage provision or the Conversion of Medical Benefits provision described in the Certificate of Coverage.

Current Carrier Information

Does the group currently have any coverage with UnitedHealthcare or has the group had any UnitedHealthcare coverage in the last 12 months? ☐ Yes ☐ No If Yes, please provide policy number _____ and Coverage Begin Date___/___ /___ End Date___/___ /___
Has this group been covered for major dental services for the previous 12 consecutive months? ☐ Yes ☐ No

		Name of Carrier	Coverage Begin Date	Coverage End Date
Current Medical Carrier	☐ None			
Current Dental Carrier	☐ None			
Current Vision Carrier	☐ None			
Current Life Carrier	☐ None			
Current Disability Carrier	☐ None			

Questions Regarding Group Size

☐ COBRA ☐ St. Continuation	Under federal law, if your group had 20 or more employees on your payroll on at least 50% of the group's working days of the preceding calendar year, you must provide employees with COBRA continuation. If your group had fewer than 20 employees, you must provide State Continuation.
☐ Medicare Primary ☐ Plan Primary	Under federal law, if your group had 20 or more employees during 20 or more calendar weeks in the preceding calendar year, the Health Plan is primary and Medicare is secondary. This statement does not set forth all rules governing group level Medicare status. The Group should contact its legal and/or tax advisor(s) for information regarding other rules that may impact the Group's Medicare status. Under federal law it is the Group's responsibility to accurately determine its Medicare status.
☐ Yes ☐ No	Are there any other entities associated with this group that are eligible to file a combined tax return under Section 414 of the Internal Revenue Code? If yes, please give the legal names of all other corporations and the number of employees employed by each.
☐ Yes ☐ No	Is your group a Professional Employer Organization (PEO) or Employee Leasing Company (ELC), or other such entity that is a co-employer with your client(s) of client-site employee(s)? If you answered Yes, then by signing this application you agree with the certification in this section. I hereby certify that my company is a PEO, ELC or other such entity and that only those employees that are the corporate employees of my company, and not my co-employees, are permitted to enroll in this group policy. If my group at any point after I sign this application determines that the group will provide coverage to the co-employees under the group's plan, I understand that UnitedHealthcare will not cover the co-employees under this group policy.

Important Information

I understand that the Certificate of Coverage or Summary Plan Description, and other documents, notices and communications regarding the coverage indicated on this application may be transmitted electronically to me and to the Group's employees.

I represent that, to the best of my knowledge, the information I have provided in this application – including information regarding qualified beneficiaries and dependents who have elected continuation under COBRA or state continuation laws – is accurate and truthful. I understand that UnitedHealthcare and Affiliates will rely on the information I provide in determining eligibility for coverage, setting premium rates, and other purposes, and that any misrepresentation or fraudulent statement may result in rescission of the group policy, termination of coverage, increase in premiums retroactive to the policy date, or other consequences as permitted by law.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

UnitedHealthcare disclosure regarding producer compensation: We pay brokers and agents (referred to collectively as "producers") compensation for their services in connection with the sale of our insured products, in compliance with applicable law. We pay "base commissions" based on factors such as product type, amount of premium, group size and number of employees. These commissions are reflected in the premium rate. In addition, we may pay bonuses pursuant to bonus programs established from time to time which are designed to encourage the introduction of new products and provide incentives to achieve production targets, persistency levels, growth goals or other objectives. Bonus expenses are not directly reflected in the premium rate but are included as part of the general administrative expenses. It is our policy not to pay commissions to producers with respect to a product for which the customer is also paying the producer a commission or other fee. Please note we also make payments from time to time to producers for services other than those relating to the sale of policies (for example, compensation for services as a general agent or as a consultant).

Producer compensation is subject to disclosure on Schedule A of the ERISA Form 5500 for customers governed by ERISA. We provide Schedule A reports to our customers pursuant to federal law. We also have taken steps to ensure that producers properly disclose their compensation arrangements to their customers, but we cannot guarantee the producer's compliance. For general information on our producer payment arrangements, including the approximate percentage of total compensation that total bonus payments comprise, please go to http://www.uhc.com and enter the term "overview of producer compensation" in the search box. For specific information about the compensation payable with respect to your particular policy, please contact your producer.

Signature

Group Authorized Signature	Title	Date

Commission Information

Writing Broker Name	Writing Broker SSN		Is the Broker appointed with UHC? ☐ Yes ☐ No
Commissions Payable to:	CRID Code (for internal use)	Tax ID#	If more than 1 Broker*, Split _____%
Street Address	City	State	Zip Code
Broker Phone #	Broker Email Address	Broker Fax Number	

The contents of this application were fully explained during a meeting with the Group submitting this application. Coverage, eligibility, pre-existing condition limitations, the effect of misrepresentations, and termination provisions were discussed.	**Broker Signature**	**Date**

*If more than 1 Broker, provide the second Broker's information on an additional sheet of paper.

UHC Sales Representative/Account Executive

Sales Representative or Account Executive (First & Last Name)

General Agent Override Information

General Agent	Phone #	Franchise Code	
Street Address	City	State	Zip Code

Admin Kit

Send Admin Kit To:	Address

[YOUR STATE INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS TO SMALL EMPLOYERS OF [2-50] EMPLOYEES, INCLUDING A BASIC OR STANDARD HEALTH BENEFIT PLAN, UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE HEALTH STATUS OF ANY OF THE INDIVIDUALS IN THE GROUP.]

SERFF Tracking Number:	*UHLC-126065434*	*State:*	*Arkansas*
Filing Company:	*Unimerica Insurance Company*	*State Tracking Number:*	*41747*
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Erollment Application Enrollment Form*		
Project Name/Number:	*/*		

Note To Filer

Created By:
Rosalind Minor on 03/11/2009 10:05 AM
Last Edited By:
Rosalind Minor
Submitted On:
03/11/2009 10:05 AM
Subject:
Underwriting Company
Comments:
I re-opened this file because I realized after the fact that the enrollment for does not have the underwriting company listed.

Please replace the form with one that has the name of the underwriting company, Unimerica Insurance Company.

SERFF Tracking Number:	*UHLC-126065434*	*State:*	*Arkansas*
Filing Company:	*Unimerica Insurance Company*	*State Tracking Number:*	*41747*
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Erollment Application Enrollment Form*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: SB.ER.09.AR 02/09

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	SB.ER.09.AR 2/09	Application/ Enrollment Form	Employer Application Enrollment Form	Initial			SB ER 09 ARrevised.pdf

(DO NOT STAPLE)

Employer Application for Small Business

[Groups with 2-99 Eligible Employees]

BAR CODE HERE

UnitedHealthcare®
A UnitedHealth Group Company

To avoid processing delays, please make sure you:
1 Answer all questions completely and accurately.
2 Complete and submit the Product and Benefit Selection Form, if applicable.
3 Submit the most recent billing statement listing those currently insured and current status.
4 Submit most recent wage and tax information.
5 Include a deposit check for any required premiums.
6 DO NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTIFICATION OF APPROVAL.

Requested Effective Date

General Information

Group's Legal Name

Group Name to appear on ID card (maximum 30 characters)

Street Address | Tax ID

City | State | Zip Code | Names of Owners/Partners (if applicable)

Contact Person | Telephone | Fax | Email Address

Billing Address (If Different) | # of Years in Business

Organization Type ☐ Partnership ☐ C-Corp ☐ S-Corp ☐ LLC/LLP ☐ Ind. Contractor ☐ Sole Proprietor ☐ Other_____ | Nature of Business | Industry (SIC) Code

Multi-Location Group* ☐ Yes ☐ No | # Locations | Address(es) (or list on additional sheet of paper)

*If you are an employer with a majority of your employees out of the submission state your benefit plans may vary based upon applicable state regulations.

Subject to ERISA regulation ☐ Yes ☐ No

Waiting Period for new hires
☐ 1st of Policy Month following Date of Hire
☐ 1st of Policy Month following ____ [months] [days] of employment
☐ Date of Hire (no waiting period)
☐ ____ [months] [days] of employment following Date of Hire

Waiting Period waived for initial enrollees ☐ Yes ☐ No

Medical Benefit Plan Option ☐ Calendar Year ☐ Policy Year

Have Workers' Comp ☐ Yes ☐ No | Workers' Comp Carrier Name | Names of Owners/Partners not covered by Workers' Comp:

Names of Persons currently on COBRA/Continuation, and/or Short/Long Term Disability: ☐ See Attached List ☐ None

Classes Excluded: ☐ None ☐ Union ☐ Hourly ☐ Non-Management ☐ Non-Owners

Participation		# Employees Applying for:		# Employees Waiving for:		Contribution	Employer %	Employer % for Dep
# Eligible Employees		Medical		Medical		Medical		
# Ineligible Employees		Dental		Dental		Dental		
Total # Employees		Vision		Vision		Vision		
		Basic Life/AD&D		Basic Life/AD&D		Basic Life/AD&D		
		Dep Life		Dep Life		Dep Life		
# Hours per week to be eligible** _____		Supp Life/AD&D		Supp Life/AD&D		Supp Life/AD&D		
		Dep Supp Life/AD&D		Dep Supp Life/AD&D		Dep Supp Life/AD&D		
		STD		STD		STD		
**For Disability products the minimum # of work hours per week to be eligible is 30 hours.		STD Buy Up		STD Buy Up		STD Buy Up		
		LTD		LTD		LTD		
		LTD Buy Up		LTD Buy Up		LTD Buy Up		
		Other		Other		Other		

Coverage Provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by UnitedHealthcare Insurance Company or United HealthCare of Arkansas, Inc.
Dental coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company
Life Insurance coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company
Vision coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company

General Information (continued)

Do you currently offer or intend to offer a Health Reimbursement Account (HRA) plan and/or comprehensive supplemental insurance policy or funding arrangement in addition to this UnitedHealthcare medical plan?
Answers must be accurate whether purchased from UnitedHealthcare or any other insurer or third party administrator.
HRA ☐ Yes ☐ No
If yes, please identify type: ☐ UnitedHealthcare Definity HRA (any HRA design offered through UnitedHealthcare) ☐ Other Administrator HRA
HRA plans administered by other insurers or third party administrators must comply with UnitedHealthcare HRA design standards.

Comprehensive Supplemental Insurance Policy or Funding Arrangement ☐ Yes ☐ No

If you answered "Yes" to either question above, you must choose from the list of UnitedHealthcare Definity HRA-eligible medical plans as shown to you by your broker or agent. Other plans are not eligible for pairing with these arrangements. Purchase of such arrangements at any point during the duration of this policy will require you to notify UnitedHealthcare.

What is your administrative policy regarding termination of eligibility for benefits related to your medical policy (including, but not limited to termination following a leave of absence)? (Please refer to the applicable state and federal rules that may require benefits to be provided for a specific length of time while an employee is on leave.)

☐ Last Day worked (following the last day worked for the minimum hours required to be eligible)
☐ 3 Months (following the last day worked for the minimum hours required to be eligible)
☐ 6 Months (following the last day worked for the minimum hours required to be eligible)
☐ UnitedHealthcare Policy Special Provisions Related to Medical Eligibility*
☐ Other (please provide a copy for our records)

***UnitedHealthcare Special Provisions Related to Medical Eligibility**

If the employer continues to pay required medical premiums and continues participating under the medical policy, the covered person's coverage will remain in force for: (1) No longer than 3 consecutive months if the employee is: temporarily laid-off; in part time status; or on an employer approved leave of absence. (2) No longer than 6 consecutive months if the employee is totally disabled.

If this coverage terminates, the employee may exercise the rights under any applicable Continuation of Medical Coverage provision or the Conversion of Medical Benefits provision described in the Certificate of Coverage.

Current Carrier Information

Does the group currently have any coverage with UnitedHealthcare or has the group had any UnitedHealthcare coverage in the last 12 months? ☐ Yes ☐ No If Yes, please provide policy number _____ and Coverage Begin Date___/___ /___ End Date___/___ /___
Has this group been covered for major dental services for the previous 12 consecutive months? ☐ Yes ☐ No

		Name of Carrier	Coverage Begin Date	Coverage End Date
Current Medical Carrier	☐ None			
Current Dental Carrier	☐ None			
Current Vision Carrier	☐ None			
Current Life Carrier	☐ None			
Current Disability Carrier	☐ None			

Questions Regarding Group Size

☐ COBRA ☐ St. Continuation	Under federal law, if your group had 20 or more employees on your payroll on at least 50% of the group's working days of the preceding calendar year, you must provide employees with COBRA continuation. If your group had fewer than 20 employees, you must provide State Continuation.
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☐ Yes ☐ No	Are there any other entities associated with this group that are eligible to file a combined tax return under Section 414 of the Internal Revenue Code? If yes, please give the legal names of all other corporations and the number of employees employed by each.
☐ Yes ☐ No	Is your group a Professional Employer Organization (PEO) or Employee Leasing Company (ELC), or other such entity that is a co-employer with your client(s) of client-site employee(s)? If you answered Yes, then by signing this application you agree with the certification in this section. I hereby certify that my company is a PEO, ELC or other such entity and that only those employees that are the corporate employees of my company, and not my co-employees, are permitted to enroll in this group policy. If my group at any point after I sign this application determines that the group will provide coverage to the co-employees under the group's plan, I understand that UnitedHealthcare will not cover the co-employees under this group policy.

Important Information

I understand that the Certificate of Coverage or Summary Plan Description, and other documents, notices and communications regarding the coverage indicated on this application may be transmitted electronically to me and to the Group's employees.

I represent that, to the best of my knowledge, the information I have provided in this application – including information regarding qualified beneficiaries and dependents who have elected continuation under COBRA or state continuation laws – is accurate and truthful. I understand that UnitedHealthcare and Affiliates will rely on the information I provide in determining eligibility for coverage, setting premium rates, and other purposes, and that any misrepresentation or fraudulent statement may result in rescission of the group policy, termination of coverage, increase in premiums retroactive to the policy date, or other consequences as permitted by law.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

UnitedHealthcare disclosure regarding producer compensation: We pay brokers and agents (referred to collectively as "producers") compensation for their services in connection with the sale of our insured products, in compliance with applicable law. We pay "base commissions" based on factors such as product type, amount of premium, group size and number of employees. These commissions are reflected in the premium rate. In addition, we may pay bonuses pursuant to bonus programs established from time to time which are designed to encourage the introduction of new products and provide incentives to achieve production targets, persistency levels, growth goals or other objectives. Bonus expenses are not directly reflected in the premium rate but are included as part of the general administrative expenses. It is our policy not to pay commissions to producers with respect to a product for which the customer is also paying the producer a commission or other fee. Please note we also make payments from time to time to producers for services other than those relating to the sale of policies (for example, compensation for services as a general agent or as a consultant).

Producer compensation is subject to disclosure on Schedule A of the ERISA Form 5500 for customers governed by ERISA. We provide Schedule A reports to our customers pursuant to federal law. We also have taken steps to ensure that producers properly disclose their compensation arrangements to their customers, but we cannot guarantee the producer's compliance. For general information on our producer payment arrangements, including the approximate percentage of total compensation that total bonus payments comprise, please go to http://www.uhc.com and enter the term "overview of producer compensation" in the search box. For specific information about the compensation payable with respect to your particular policy, please contact your producer.

Signature

Group Authorized Signature	Title	Date

Commission Information

Writing Broker Name	Writing Broker SSN		Is the Broker appointed with UHC? ☐ Yes ☐ No
Commissions Payable to:	CRID Code (for internal use)	Tax ID#	If more than 1 Broker*, Split _____%
Street Address	City	State	Zip Code
Broker Phone #	Broker Email Address	Broker Fax Number	

The contents of this application were fully explained during a meeting with the Group submitting this application. Coverage, eligibility, pre-existing condition limitations, the effect of misrepresentations, and termination provisions were discussed.	**Broker Signature**	**Date**

*If more than 1 Broker, provide the second Broker's information on an additional sheet of paper.

UHC Sales Representative/Account Executive

Sales Representative or Account Executive (First & Last Name)

General Agent Override Information

General Agent	Phone #	Franchise Code	
Street Address	City	State	Zip Code

Admin Kit

Send Admin Kit To:	Address

[YOUR STATE INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS TO SMALL EMPLOYERS OF [2-50] EMPLOYEES, INCLUDING A BASIC OR STANDARD HEALTH BENEFIT PLAN, UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE HEALTH STATUS OF ANY OF THE INDIVIDUALS IN THE GROUP.]

SERFF Tracking Number:	*UHLC-126065434*	*State:*	*Arkansas*
Filing Company:	*Unimerica Insurance Company*	*State Tracking Number:*	*41747*
Company Tracking Number:			
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Erollment Application Enrollment Form*		
Project Name/Number:	*/*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*UHLC-126065434*	*State:*	*Arkansas*
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Project Name/Number:	*/*		

Supporting Document Schedules

Review Status:

Bypassed -Name: Flesch Certification — Approved-Closed — 03/11/2009
Bypass Reason: N/A
Comments:

Review Status:

Bypassed -Name: Application — Approved-Closed — 03/11/2009
Bypass Reason: N/A
Comments:

Review Status:

Bypassed -Name: Outline of Coverage — Approved-Closed — 03/11/2009
Bypass Reason: N/A
Comments:

Review Status:

Satisfied -Name: Cover Letter — Approved-Closed — 03/11/2009
Comments:
Attachment:
AR COVER LETTER SB ENROOLMENT 3-2-2009 Unimerica.pdf

March 2, 2009

Ms. Rosalyn Minor
Arkansas Insurance Department
1200 West 3rd Street
Little Rock, Arkansas 72201

Re: Unimerica Insurance Company
NAIC No. 91529

Dear Ms. Minor:

On behalf of Unimerica Insurance Company, I am submitting the enclosed employer application form for your Department's review and approval.

This form is our standard form and has been prepared for use in your state for group sizes 2-99 for medical, dental, vision and ancillary products. Information contained within these forms may also be used in an online format with appropriate changes in font, format and design to more easily accommodate online enrollments. We want to assure the Department that education will be provided to the brokers, employer groups and the employees as to which products are being offered for sale.

If you have any questions or concerns regarding this filing, please feel free to contact me.

Sincerely,

Ebony N. Terry
United HealthCare Insurance Company
Ph: 301.838.5611
Fax: 301.838.5676
Email: Ebony_N_Terry@uhc.com

SERFF Tracking Number:	*UHLC-126065434*	*State:*	*Arkansas*
Filing Company:	*Unimerica Insurance Company*	*State Tracking Number:*	*41747*
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TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Erollment Application Enrollment Form*		
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Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Form	Employer Application Enrollment Form	03/08/2009	SB ER 09 AR.pdf

(DO NOT STAPLE)

Employer Application for Small Business

[Groups with 2-99 Eligible Employees]

BAR CODE HERE

UnitedHealthcare®
A UnitedHealth Group Company

To avoid processing delays, please make sure you:
1 Answer all questions completely and accurately.
2 Complete and submit the Product and Benefit Selection Form, if applicable.
3 Submit the most recent billing statement listing those currently insured and current status.
4 Submit most recent wage and tax information.
5 Include a deposit check for any required premiums.
6 DO NOT CANCEL YOUR EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTIFICATION OF APPROVAL.

Requested Effective Date

General Information

Group's Legal Name

Group Name to appear on ID card (maximum 30 characters)

Street Address | Tax ID

City | State | Zip Code | Names of Owners/Partners (if applicable)

Contact Person | Telephone | Fax | Email Address

Billing Address (If Different) | # of Years in Business

Organization Type ☐ Partnership ☐ C-Corp ☐ S-Corp ☐ LLC/LLP ☐ Ind. Contractor ☐ Sole Proprietor ☐ Other_____ | Nature of Business | Industry (SIC) Code

Multi-Location Group* ☐ Yes ☐ No | # Locations | Address(es) (or list on additional sheet of paper)

*If you are an employer with a majority of your employees out of the submission state your benefit plans may vary based upon applicable state regulations.

Subject to ERISA regulation ☐ Yes ☐ No

Waiting Period for new hires
☐ 1st of Policy Month following Date of Hire
☐ 1st of Policy Month following ____ [months] [days] of employment
☐ Date of Hire (no waiting period)
☐ ____ [months] [days] of employment following Date of Hire

Waiting Period waived for initial enrollees ☐ Yes ☐ No

Medical Benefit Plan Option ☐ Calendar Year ☐ Policy Year

Have Workers' Comp ☐ Yes ☐ No | Workers' Comp Carrier Name | Names of Owners/Partners not covered by Workers' Comp:

Names of Persons currently on COBRA/Continuation, and/or Short/Long Term Disability: ☐ See Attached List ☐ None

Classes Excluded: ☐ None ☐ Union ☐ Hourly ☐ Non-Management ☐ Non-Owners

Participation		# Employees Applying for:		# Employees Waiving for:		Contribution	Employer %	Employer % for Dep
# Eligible Employees		Medical		Medical		Medical		
# Ineligible Employees		Dental		Dental		Dental		
Total # Employees		Vision		Vision		Vision		
		Basic Life/AD&D		Basic Life/AD&D		Basic Life/AD&D		
		Dep Life		Dep Life		Dep Life		
# Hours per week to be eligible** _____		Supp Life/AD&D		Supp Life/AD&D		Supp Life/AD&D		
		Dep Supp Life/AD&D		Dep Supp Life/AD&D		Dep Supp Life/AD&D		
		STD		STD		STD		
**For Disability products the minimum # of work hours per week to be eligible is 30 hours.		STD Buy Up		STD Buy Up		STD Buy Up		
		LTD		LTD		LTD		
		LTD Buy Up		LTD Buy Up		LTD Buy Up		
		Other		Other		Other		

Coverage Provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by UnitedHealthcare Insurance Company [or United HealthCare of XXX]
Dental coverage provided by UnitedHealthcare Insurance Company [or United HealthCare of XXX] or Unimerica Insurance Company
Life, Short-Term Disability (STD), Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company [or Unimerica Life Insurance Company of New York]
Vision coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company

General Information (continued)

Do you currently offer or intend to offer a Health Reimbursement Account (HRA) plan and/or comprehensive supplemental insurance policy or funding arrangement in addition to this UnitedHealthcare medical plan?
Answers must be accurate whether purchased from UnitedHealthcare or any other insurer or third party administrator.
HRA ☐ Yes ☐ No
If yes, please identify type: ☐ UnitedHealthcare Definity HRA (any HRA design offered through UnitedHealthcare) ☐ Other Administrator HRA
HRA plans administered by other insurers or third party administrators must comply with UnitedHealthcare HRA design standards.

Comprehensive Supplemental Insurance Policy or Funding Arrangement ☐ Yes ☐ No

If you answered "Yes" to either question above, you must choose from the list of UnitedHealthcare Definity HRA-eligible medical plans as shown to you by your broker or agent. Other plans are not eligible for pairing with these arrangements. Purchase of such arrangements at any point during the duration of this policy will require you to notify UnitedHealthcare.

What is your administrative policy regarding termination of eligibility for benefits related to your medical policy (including, but not limited to termination following a leave of absence)? (Please refer to the applicable state and federal rules that may require benefits to be provided for a specific length of time while an employee is on leave.)

☐ Last Day worked (following the last day worked for the minimum hours required to be eligible)
☐ 3 Months (following the last day worked for the minimum hours required to be eligible)
☐ 6 Months (following the last day worked for the minimum hours required to be eligible)
☐ UnitedHealthcare Policy Special Provisions Related to Medical Eligibility*
☐ Other (please provide a copy for our records)

***UnitedHealthcare Special Provisions Related to Medical Eligibility**

If the employer continues to pay required medical premiums and continues participating under the medical policy, the covered person's coverage will remain in force for: (1) No longer than 3 consecutive months if the employee is: temporarily laid-off; in part time status; or on an employer approved leave of absence. (2) No longer than 6 consecutive months if the employee is totally disabled.

If this coverage terminates, the employee may exercise the rights under any applicable Continuation of Medical Coverage provision or the Conversion of Medical Benefits provision described in the Certificate of Coverage.

Current Carrier Information

Does the group currently have any coverage with UnitedHealthcare or has the group had any UnitedHealthcare coverage in the last 12 months? ☐ Yes ☐ No If Yes, please provide policy number _____ and Coverage Begin Date___/___ /___ End Date___/___ /___
Has this group been covered for major dental services for the previous 12 consecutive months? ☐ Yes ☐ No

		Name of Carrier	Coverage Begin Date	Coverage End Date
Current Medical Carrier	☐ None			
Current Dental Carrier	☐ None			
Current Vision Carrier	☐ None			
Current Life Carrier	☐ None			
Current Disability Carrier	☐ None			

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